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Grassley Works to Stop Improper Payments for Psychiatric Services in Nursing Homes

WASHINGTON – Sen. Chuck Grassley, lead Republican on the Committee on Finance, today asked the Centers for Medicare and Medicaid Services to end the longstanding problem of improper payments for psychiatric services in nursing homes. Grassley's request letter follows.

October 9, 2001

Mr. Tom Scully
Administrator
The Centers for Medicare and Medicaid Services
200 Independence Ave. SW
Room 314-G
Washington, D.C. 20201

Dear Administrator Scully:

I am writing to follow up on a report completed by the Office of Inspector General (OIG) in January of 2001 related to Medicare payments for psychiatric services in nursing homes. Section 1862(a)(1)(A) of the Social Security Act states that all Medicare Part B services including psychiatric services, must be "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member."

The January 2001 OIG report found that 39% of Medicare payments for psychiatric services in nursing homes are either medically unnecessary, have no mental health documentation, or are questionable. The most problematic of the services reviewed by the OIG was psychological testing. The OIG report also showed that utilization guidelines related to psychiatric services in nursing homes are inconsistent and unclear.

This is not a new issue for the Centers for Medicare and Medicaid Services (CMS). In fact, it has been an ongoing problem for the last four years. The OIG issued a report (May of 1996) which found that nearly half of all Medicare psychiatric services in nursing facilities were either medically unnecessary (32%) or questionable (16%). The May 1996 report also identified inadequate utilization guidelines and a lack of carrier policies and screens specific to nursing facilities.

As a result of their January 2001 study, the OIG recommended that HCFA (now CMS) consider the following:

1. Work with carriers to develop guidelines for the appropriate frequency and duration of psychiatric services.
2. Work with carriers and mental health providers to identify the specific instruments that can be appropriately billed as psychological testing.
3. Encourage carriers to take advantage of the Minimum Data Set, particularly its assessment of patient cognitive level, by using it to assess the appropriateness of reimbursement for psychiatric services.

HCFA concurred with the recommendations in the OIG's January 2001 report, stating the following in response to recommendations #1 and #2: "We concur with these recommendations, and will be sharing this report with the contractors and asking them to analyze their data for psychological testing in nursing homes and to take appropriate corrective action. In addition, we are referring this report to the carrier clinical workgroup on psychiatric services for their consideration of a local medical review policy template. Finally, we will explore the possibility of including this issue in the national coverage decision process."

In response to OIG recommendation #3, HCFA stated, "We concur. We will alert all carriers regarding the potential usefulness of the Minimum Data Set during claim review. We will encourage contractors whose data analysis indicates over-utilization of psychiatric services to request the physician or nursing home supply a copy of the MDS to the carrier for review."

I am concerned that Medicare continued to pay for some inappropriate services four years after the OIG had identified payments for those services as a problem needing attention. The government has lost several million dollars in each of those years as a result of these inappropriate payments. Let me be blunt: CMS must stop making inappropriate payments for these services.

I understand that you only recently assumed the leadership of CMS and therefore bear no responsibility for HCFA's inaction on the earlier OIG recommendations. I would like some assurance, however, that you are implementing the more recent recommendations made by the OIG and working to repair what is clearly a flawed reimbursement mechanism for these services.

Therefore, can you please address my concerns related to this issue by providing answers to the following questions:

1. What efforts have been made by your agency to ensure that policies for psychiatric services provided in nursing homes are consistent and precise?
2. Have reimbursement guidelines that clearly address appropriate diagnostic codes, treatment protocols, and parameters for frequency and duration of psychiatric services been established? If so, please explain. If not, why not?
3. What progress has been made by your agency in working with carriers and mental health providers to identify specific instruments that can be appropriately billed as psychological testing? Please provide details.

4. What efforts have been made by your agency to educate carriers on the Minimum Data Set (MDS) and its use as a way to assess the appropriateness of reimbursement for psychiatric services? Please provide details.

Based on the OIG's findings in the above-mentioned reports, it is clear to me that the billing process for psychiatric services in nursing homes needs to be strengthened. The factors identified in the OIG reports, that have lead to inappropriate reimbursement, need to be addressed and changes need to be implemented promptly. I anxiously await a response from your office regarding the above questions by November 2, 2001.

Thank you for your time and attention to this matter.

Sincerely,

Charles E. Grassley
Ranking Member